CHILDBEARING PRACTICES OF MEXICAN-AMERICAN WOMEN OF TUCSON, ARIZONA

by

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STATEMENT BY AUTHOR

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ABSTRACT

This paper reports the results of research on the childbearing attitudes and behavior of Mexican-American women in Tucson, Arizona. One hundred Mexican-American women were interviewed concerning their pregnancy histories, experience with birth control, common childbearing practices, and attitudes toward bearing children. An attempt was made to determine whether Mexican-American attitudes and behavior deviated significantly from Anglo-American patterns. For this, a group of forty Anglo-Americans was utilized for control purposes.

The results of the study indicate that there are differences in childbearing behavior between Mexican-Americans and Anglo-Americans. Moreover, behavioral divergences can be more satisfactorily attributed to cultural than to economic influences. Mexican-American childbearing behavior departs from Anglo-American behavior in three distinct areas relating to kinship, religion, and diet. The traits comprising these areas are not retentions from traditional Mexican culture but a complex fusion of Mexican and American practices occurring in the urban environment to suit the needs of the people. The result is a unique Mexican-American subculture. If the childbearing experience of Mexican-American women is any indication, this subculture is not confined to isolated and traditional aspects of behavior but permeates the whole of Mexican-American life.

CHAPTER 1

INTRODUCTION

This study is concerned with Mexican-American habits, values, and customs regarding the birth of children. Mexican-Americans form a minority in Tucson, Arizona with a cultural heritage different from that of Anglo-Americans. The primary interest of the research is to determine whether Mexican-American women have maintained distinct cultural patterns in the realm of childbearing--patterns which have either been retained from a Mexican background or have developed out of a fusion of Mexican and American practices. Although the study focuses upon patterns of childbearing behavior among Mexican-American women, a control group of Anglo-American women has been utilized to discover if such a cultural dimension does indeed exist in the experience of childbirth, or if on the contrary, those differences which might be found can best be attributed to the socio-economic position of Mexican-Americans within American society.

Sociologists have tended to view variant behavior of minority groups in terms of socio-economic variables. They have often attributed the lack of full participation by certain groups in the American lifeway to a disparity in socio-economic status (Grebler, Moore, and Guzman, 1970).

Anthropologists, on the other hand, have stressed cultural variables. They have more often argued that the failure of certain groups

to enter the mainstream of American life might better be attributed to the fact that they do not share our world view. Thus, they have contended that a different religious orientation and different concepts of health among other things might make it difficult for Mexican-American women to share our most firmly held beliefs on childbearing (Saunders, 1954; Clark, 1959).

For other minorities, it might be difficult to confirm that its members share a cultural orientation different from that of mainstream Anglo-Americans. Two factors have tended to reinforce the image of a separate Mexican-American identity. First, the tenacity with which Mexican-Americans have maintained their language has marked them as a group apart. Grebler et al. (1970: 423-424) state:

> An extensive study of "language loyalty" among ethnic groups in the United States shows conclusively that Spanish is the most persistent of all foreign languages, and the one with the greatest prospects of survival. It is Mexican-Americans who are the main contributors to this tendency; they appear to have diverged substantially from the usual pattern of dissolution of old-country language use over succeeding generations in the United States.

Second, Mexican-Americans are assumed to share the inheritance of a proximate ancestral culture. Information about Spanish-American culture, including its Mexican manifestations (Foster, 1960), and data about the peoples of Mexico, coming from such studies as those by Foster (1967) and Lewis (1960), have provided an excellent source of comparison for cultural patterns exhibited by Mexican-Americans. The problem with the latter group of studies is that they depict particular Mexican folk communities, and one must be aware of the dangers of generalizing from the particular folk community to "Mexican culture" and

from there to a specific Mexican-American population, the antecedents of which cannot be traced to the folk community in question (for a detailed discussion of this problem, see Weaver, 1968). Despite the problems involved in such generalizations, the abstraction "Mexican culture" has been employed by a variety of anthropologists seeking to determine its influence on Mexican-American values, attitudes, and behavior. Perhaps none has utilized it quite so explicitly and extensively as William Madsen (1964: 2) who contends that " . . . Mexican-American folk society still retains the core values of Mexican culture."

Nevertheless, the idea that cultural influences, derived ultimately from Mexico, are strong determining forces in shaping the behavior of Mexican-Americans has been disputed by Grebler et al. (1970) among others, who maintain that when Mexican-Americans have access to economic resources they quickly become assimilated into the American lifeway, so that they become "typical Americans."

This research attempts to provide concrete data, rather than inferences, about Mexican-American childbearing in order to determine if it differs from Anglo-American practices, and if so, whether the main contribution to that difference is cultural or socio-economic. The study will determine this indirectly by first comparing Mexican-Americans with Anglo-Americans, then comparing groups defined by socio-economic criteria, such as income. If the groups vary more significantly according to one criterion than another, the assumption will be that this criterion, be it ethnicity, income, education, or whatever, has the greatest impact upon recorded behavior and attitudes.

Studies on Mexican-Americans have been extensive. One of the main problems with the majority of these studies has been their almost exclusive focus upon small, homogeneous rural communities. The emphasis has been upon cultural retention and distinctiveness rather than upon a representation of beliefs and behavior exhibited by a wide spectrum of Mexican-Americans. Moustafa and Weiss (1968: 38) address this problem in a preface to a review of the literature on health attitudes and practices:

> The following discussion applies only to an extreme, in which most or all of the notions about illness and disease are derived from the old Spanish and American Indian cultures. This limitation is imposed by the literature which emphasizes the "deviations" from what are presumed to be prevailing health attitudes and practices in the larger society. To our knowledge, none of the existing research has systematically explored the question of how many Mexican-Americans are involved in these deviations from the norm, and how they distinguish themselves from other members of the ethnic group with regard to rural or urban location, native or foreign-born status, and economic position. Consequently the statements here should be understood to apply to a segment of the Spanish-surname population, the size and composition of which are virtually unknown. Unknown also is any change over time in the adoption of "modern" beliefs, attitudes, practices.

Childbearing studies have fallen into this category. This study then has attempted to fill the void created by research which has centered almost entirely on traditional communities. The research focuses upon an urban segment of society in which the parameters are clearly defined. By studying Mexican-American women who range in age from 18 to 57, inferences can be made about a possible change of behavior over time. Data were collected concerning place of birth of women in order to distinguish differences in behavior between native

and foreign-born individuals. And, finally, behavior has been correlated with socio-economic variables.

This study can be defended on a more practical level. Government health officials have been forced to deal with problems such as why Mexican-American women delay in attending pre-natal clinics (Reeder and Reeder, 1964: 1308). If there is indeed a difference in Mexican-American childbearing behavior which can be ascribed to a different cultural focus, those aspects which are variants ought to be investigated and defined.

CHAPTER 2

BACKGROUND STUDIES

There are a number of studies that provide background informa-on Mexican-Americans living in various parts of the United States, primarily in the Southwest (see Burma, 1954; Getty, 1949; Gonzalez, 1969; Grebler et al., 1970; Madsen, 1964; Officer, 1964; Tuck, 1956 among others). They range from an attempt at a comprehensive report on Mexican-Americans in urban centers of the Southwest (Grebler et al., 1970) to studies of small homogeneous communities (Madsen, 1964). One of the main problems with such studies is that it is difficult to utilize specific information because of what Grebler et al. (1970: 292) have called "the existence of a great deal of internal differentiation among the Mexican-American people."

For this reason, the unpublished doctoral dissertation of James Officer, "Sodalities and Systematic Linkage: the Joining Habits of Urban Mexican-Americans," takes on added significance. This is probably the most recent and comprehensive study of Tucson Mexican-Americans. Mexican-Americans comprise approximately 18 percent of the total population of Tucson and have lived in relative harmony with the Anglo-American population for well over a century. Mexican-American residents of the city are not primarily agricultural workers, as in other localities of the Southwest and therefore the bracero program did not pose a threat to inhabitants of the city. Residential

separation, nevertheless, has been common. The proximity of the border (about 68 miles away) has undoubtedly affected the characteristics of the Mexican-American community. It is fairly easy and not unusual to maintain close contact with friends and relatives in Mexico. One of the most striking characteristics noted by Officer is the homogeneity of the Mexican-American population. Over 70 percent of the Mexican-Americans living in Tucson were born or descended from persons born in Sonora, Mexico. Officer (1964: 73) states: "Having knowledge of this fact not only prepared me to expect a high degree of cultural homogeneity within the colony, but also to look for behavioral differences between the Tucson Mexicans and those in other large southwestern cities." Officer's study is also pertinent to this one in that it contains a rather brief but excellent discussion of certain folk practices relating to childbearing which Officer uncovered in his discussions with Mexican-Americans and with city health personnel.

Likewise, the literature on peasant societies, from which Mexican culture has been abstracted, is extensive. Some of the best of these studies were done by Foster (1967) and Lewis (1960). Data most pertinent to this research include those on life cycle, especially childbirth, and peasant classifications of disease and illness. Although such material was useful in the interpretation of some data collected during this research, its limitations must be noted, since none of the studies are concerned with Sonora, the area of Mexico from which most Tucson Mexican-Americans come. More important, these studies focus upon rural Mexicans, while the concern here is with urban Mexican-Americans.

A number of studies, foremost among them those by Saunders (1954), Clark (1959), and Madsen (1964) have dealt directly with concepts of health and illness held by Mexican-Americans. They have tended to stress divergences from Anglo-American ideas and practices. Thus, Saunders (1954: 5) focuses upon "differences . . . which are manifestations of a conditioning in and by a cultural group that includes among its beliefs, practices and patterns of relationships many that are different from those of the dominant natively English speaking population of the United States." In a section on birth practices, Saunders (1954: 155-157) summarizes the results of research done by Sister Lucia van der Eerden (1948) on maternity care in an isolated rural New Mexican community, in which the majority of women are delivered by midwives, and a whole constellation of traditional practices surrounding childbirth is observed. Likewise Clark (1959: 119-129), although studying a more modern and urban Mexican-American community, isolates those activities and beliefs which diverge from American ones. She tells, for instance, of traditional home remedies believed by Mexican-American women to aid conception and of the belief that certain foods can mark an unborn child. Madsen (1964: 70) notes that the women of his study are receiving more modern medical care during pregnancy and childbirth, and that this is quickly becoming the norm among Mexican-Americans of Hidalgo County, Texas. Nevertheless, he, too, dwells on the more traditional practices like home births and folk beliefs such as the one concerning the ill effects on an unborn child of an eclipse of the moon. These studies were undertaken for the specific purpose of acquainting Anglo-American medical personnel with

health practices and beliefs held by Mexican-Americans which differ from their own and thus aiding cross-cultural understanding between the two groups. Because of their particular point of view, these studies represent a somewhat skewed picture of Mexican-American child-bearing attitudes and practices. Here the caveat of Moustafa and Weiss should be borne in mind (see pp. 4-5).

Finally, there are a number of studies specifically relating to childbearing. These studies fall into two main categories, those that are anthropologically oriented and those that are sociologically oriented. The former focus primarily upon cultural variables, but do not include studies on urban ethnic populations in the United States. The latter do focus upon such populations, but the concern is generally with low-income women.

Within the second group are studies which focus primarily upon specific problems. Reeder and Reeder (1964) seek to isolate those factors which affect the incidence of prenatal care among low-income women. Their sample of women attending prenatal clinic includes a group which they label Latin American and one of the findings is that this group shows a tendency for being least prompt in seeking prenatal care.

An unpublished study by Kay (1967) which is similar in orientation seeks to determine why some mothers fail to receive prenatal care of any kind. This research done in Tucson compares walk-ins, women who have received no medical attention prior to the advent of labor to low-income women who received prenatal care. Over half of

both groups comprising the sample populations were Mexican-Americans, and Kay (1967: 5) cites certain cultural factors which have retarded the acceptance of prenatal care among this ethnic group. Among these factors are greater concern with infringement of personal modesty, unfulfilled expectations of receiving traditional folk treatments such as massage, and a tendency to fatefully accept the course of the pregnancy as part of "God's plan."

Wider in scope in terms of describing the maternity practices of the populations studied are the anthropological studies. Included in this group is an unpublished study by Kay (1966) which documents the childbearing practices of women in the state of Jalisco, Mexico and particularly in the city of Guadalajara. The author sees childbearing practices there undergoing a decided process of change, and she distinguishes two main groups, those who are delivered at home and those who are delivered in the hospital. Among those in the first category, folk beliefs and traditional practices prevail. Women see the midwife, who may or may not be qualified, at least a couple of times during the pregnancy, but usually only to receive massages. Herbs, to which are attributed various powers, are taken. During the birth, a prescribed pattern of activity is followed under the direction of the midwife. Beliefs about diet, burial of the umbilical cord, and folk diseases to which the mother and newborn are susceptible are all recorded by Kay. In contrast, Kay reports a pattern of childbearing practices observed by mothers who deliver in the hospital to be much closer to that followed by Anglo-American women. However,

she does note greater incidence of breast feeding among other things which differentiate Mexican practices surrounding childbearing from typical Anglo-American practices.

Kelly (1965) details the customs surrounding conception, pregnancy, parturition, and postnatal care of northern Mexico, specifically the Torreón area of the state of Coahuila. She documents among others, folk beliefs and practices for inducing pregnancy and also abortion, for easing delivery, and for insuring the health of the parturient and her newborn infant. Kelly (1965: ix) notes that publications by Rubel and Madsen seem to indicate that such practices as she has described might extend at least as far north as the lower Rio Grande area.

Research on maternity practices completed almost thirty years ago by Sister Lucia van der Eerden (1948) is the only extensive published account on the subject dealing with Mexican-American women. As mentioned previously, the research was undertaken in a rural isolated village in New Mexico in which traditional practices were clung to tenaciously. Not more than one or two expectant women received prenatal care each year. Over two-thirds of the women were delivered at home by midwives despite the presence of a hospital nearby. The midwives received training from local doctors, but the expectations of the patient and her relatives often made the break from traditionally accepted practices difficult if not impossible. Herbs were in widespread use, and there were folk remedies for everything from postpartum hemorrhage to the binding of the umbilical cord. In the

words of the author, "All in all, the Spanish-American traditional pattern of maternal care predominates" (van der Eerden, 1948: 7).

The picture which this background research provides is largely one of the observance of a traditional pattern of childbearing practice derived in large part from Mexican folk beliefs. Yet a large number of Mexican-Americans reside in large urban centers where they are exposed to current Anglo-American practices. There is little information about how Mexican-American women have adjusted in the realm of childbearing. Have they maintained their traditional patterns of childbearing behavior or have they been completely assimilated into the American lifeway? This research will attempt to reflect the experiences of the majority of Mexican-American women in Tucson, Arizona rather than to dwell upon isolated traditional vestiges. It will try to assess, for example, the impact of contraceptives upon Mexican-Americans. Because of the dearth of up-to-date published information concerning childbearing among Mexican-American women, the study must rely almost entirely upon information derived from the 100 Mexican-American women interviewed for the research.

CHAPTER 3

RESEARCH DESIGN

Sampling Methods

A combination of area and cluster sampling techniques was used to select 100 Mexican-American women and 40 Anglo-American women. The 1960 Census was employed in conjunction with the Tucson City Directory to locate the sample (Polk, 1969).

The research was conducted in the 19 census tracts (see accompanying map in Appendix B) in which there was some concentration of Mexican-Americans, i.e., those tracts which were singled out by the Census as containing at least 400 individuals with Spanish surnames. The percentage of Mexican-American families in each tract, based upon the total number of families in the tract, was calculated and used to determine the number of Mexican-American families chosen from each tract for the sample.

A city census map, in which the city blocks in each census tract were numbered, was used to select the blocks from which the sample was to be taken. This selection was undertaken by means of a random number table. Then, through the use of the Tucson City Directory, the households of Spanish surname on each block were recorded. These households were numbered and finally selected for inclusion by using a table of random numbers. If there were no households of

Spanish surname on the block, another block was chosen by the same procedure specified above.

The selection of an Anglo-American sample to serve as a control group proved to be more difficult to make. The sample was chosen from the same nineteen-tract area. However, because of the scarcity of Anglo-Americans in some densely Mexican-American census tracts, the percentage of Anglo-Americans used from each tract was a percentage of its representation in that tract. Thus the Mexican-American sample is not strictly comparable to the Anglo-American sample, since a tract which is represented by a large proportion of Mexican-Americans in the sample will be represented by a small percentage of Anglo-Americans and vice-versa. Likewise, because of an inability to locate Anglo-Americans in certain census tracts, some census tracts were dropped and thus there is Anglo-American representation from the following twelve census tracts: 04, 07, 09, 10, 20, 23, 24, 25 35, 38, 39, 45. The consequences of the necessary compromise in choosing the Anglo-American sample are apparent. More Anglo-Americans have been chosen from census tracts with better socio-economic conditions. Thus the average income among Anglo-Americans in the sample is approximately $1,000 more than among the Mexican-Americans ($6,715 compared to $5,728), while the average education of the male family head is 12 years for the Anglo-American and only 9 years for the Mexican-American. It is regrettable that the Mexican-American and Anglo-American samples of the population could not be strictly matched in terms of residential location and the socio-economic indicators of income and education.

However, the samples chosen more accurately reflect the conditions of both the Mexican-American and Anglo-American in the area studied. Nonetheless, the reader is warned again that the two samples are not strictly comparable and this must be taken into account in the analysis of data.

In both samples, only those women with at least one child under the age of 18 have been included.

Elicitation of Data

Data are of two kinds, quantifiable data which can be analyzed statistically and non-quantifiable data on specific customs and practices as revealed by informants through open-ended interviews. The data were elicited through the use of an interview schedule (see Appendix A). Each informant was asked very specific information about her own and her husband's personal history. The woman was then asked to relate certain information regarding her pregnancy history. The non-quantifiable data were obtained by informal discussion. Some of the topics discussed were diet of a pregnant woman, attitudes toward the family, and feelings about birth control.

Statistics Utilized

I began with the premise that the behavior and attitudes of Mexican-American women were different from those of Anglo-American women. Furthermore, I presumed that unacculturated Mexican-Americans (defined as those Mexican-Americans who spoke only Spanish) would depart even further than acculturated Mexican-Americans from Anglo-American norms. Therefore, for purposes of statistical analysis, the

women have been divided into three groups: unacculturated Mexican-Americans, acculturated Mexican-Americans, and Anglo-Americans. Two techniques have been used to confirm or deny statistically significant differences among the three groups--analysis of variance, used on numerical data, and chi square, used on nominal data. Appendix C provides a brief explanation of the statistics used in the analysis of data.

However, there existed the strong possibility that socio-economic factors were the real determining ones in the behavior exhibited by Mexican-Americans. Thus, it has been necessary to analyze the data in terms of variables which could be defined specifically as socio-economic ones. Three variables seemed to fall into this category --family income, education of father and education of mother. The latter two had to be rejected for comparative purposes because of the dissimilarity of the two populations in these areas. The Anglo-Americans interviewed, both men and women, are unrepresented in a group having less than an eighth grade education and over-represented in relation to Mexican-Americans in the group of high school graduates. Though the statistical data reflect the behavior of poorly educated (less than eighth grade education) Mexican-Americans, there is no comparable data for Anglo-Americans. In contrast, Anglo-Americans and Mexican-Americans are represented in all income groups devised for the study, even though income level is higher for Anglo-Americans than for Mexican-Americans. Although we must still take into account the fact that the two populations are not perfectly matched, income is the only

valid indicator of socio-economic status which can be used for both groups. However, other socio-economic variables can be used, includ- education of the father and mother, as well as age and occupation of mother, and religion, in testing the Mexican-Americans alone. This will enable us to assess the impact of socio-economic position upon childbearing behavior among the Mexican-Americans only.

I had originally intended to utilize multiple classification analysis of variance in order to test for possible interaction of such variables as ethnicity and income. This proved unfeasible because of the nature of the data collected for this study. (This statistic requires either equal or proportional N in each group. Because there were so many instances where information was not provided by one or more informants, it would have been difficult under the conditions of this research to maintain proportional groups for the testing of each independent variable.) However, it is possible to look at the com- puted averages to make suggestions about possible interactions and thus to point the way to further research on the subject.

CHAPTER 4

ANALYSIS OF STATISTICAL DATA

The statistical data presented in Table 1 provide a description of the population studied, as it is divided into groups on the basis of ethnicity/language. The following is a more literary translation of the definition of the population, making only the very basic distinction between Mexican-Americans and Anglo-Americans.

Description of the Mexican-American Population of the Sample

From the data collected, it is possible to present a composite picture of the average Mexican-American woman interviewed, her husband, and her experiences during pregnancy and the birth of her children. Mrs. Garcia, as she might have been called, is 35 years old. She was married at the age of 20 and has remained married. She is traditional in her role as housewife and in clinging to the religion of her ancestors, Roman Catholicism. She was born in Tucson, raised in a family of 7 or 8 children, and attended school until the middle of the seventh grade. Her husband is 37. He also is a native of Tucson and came from a family of 7 children. He had barely more education than his wife, leaving school after the eighth grade. His income is approximately $5,725 per year.

Mrs. Garcia bore her first child when she was 21 years old and had a child approximately every 33 months thereafter. She and her husband presently have four children, all of whom were delivered in

Table 1. Profile of Population (Averages and Percentages)

MOTHER	Anglo-Americans	Mexican-Americans	Spanish-Speaking Mexican-Americans	English-Speaking Mexican-Americans
1. Age	33.15	35.04	36.87	34.45
2. Age at Marriage	18.93	20.21	21.35	19.87
3. Number in Family	4.64	7.31	8.09	7.09
4. Age at Birth of 1st Child	21.23	21.29	22.83	20.83
5. Months between Marriage & 1st Child	21.43	10.74	11.91	10.38
6. Years of Education	11.52	8.12	5.78	8.82
7. Marital Status				
Married	75.0%	89.0%	87.0%	89.5%
Divorced	15.0%	7.0%	4.4%	7.8%
Widowed	2.5%	1.0%	0.0%	1.3%
Separated	2.5%	3.0%	8.6%	1.4%
8. Religion				
Catholic	37.5%	94.0%	87.0%	96.1%
Protestant	62.5%	6.0%	13.0%	3.9%
9. Occupation				
Housewife	60.0%	77.8%	78.3%	76.6%
Full-time Employee	30.0%	13.1%	13.0%	14.3%
Part-time Employee	10.0%	9.1%	8.7%	9.1%
10. Birthplace				
Tucson	7.5%	51.0%	0.0%	66.4%
Arizona	2.5%	9.0%	4.3%	10.4%
Mexico	0.0%	23.0%	74.0%	7.8%
Border Towns	0.0%	8.0%	8.7%	7.8%
Southwest	0.0%	8.0%	13.0%	6.5%
United States	90.0%	1.0%	0.0%	1.3%

Table 1. Profile of Population (Averages and Percentages)--Continued

FATHER	Anglo-Americans	Mexican-Americans	Spanish-Speaking Mexican-Americans	English-Speaking Mexican-Americans
11. Age	35.73	37.20	40.36	36.28
12. Education	12.08	8.71	7.50	9.01
13. Family Size	4.11	7.25	6.35	7.50
14. Income	$6,715	$5,728	$5,234	$5,852
CHILDBEARING HISTORY				
15. Number of Births	2.83	4.19	4.13	4.21
16. Number Delivered in Hospital	98.9%	85.1%	72.5%	81.5%
17. Number Delivered by Doctor	100.0%	93.9%	92.6%	92.0%
18. Number of Pregnancies Receiving Prenatal Care	98.8%	90.3%	89.5%	88.0%
19. Months of Prenatal Care	2.38	2.97	2.95	2.97
20. Nursing Time (Months)	0.90	3.74	6.22	3.00
21. Days of Bedrest	3.97	5.40	2.83	6.17
22. Ideal Family Size	3.23	4.32	4.78	4.18
23. Sedation	62.2%	62.4%	33.9%	64.0%
24. Spacing (Months)	38.53	32.71	33.83	32.35
25. Spacing after 1st Child	30.77	28.34	31.13	27.44
26. Spacing after 2nd Child	36.90	30.71	25.90	32.34
27. Spacing after 3rd Child	32.36	33.98	27.72	35.70

Table 1. Profile of Population (Averages and Percentages)--Continued

CHILDBEARING HISTORY	Anglo-Americans	Mexican-Americans	Spanish-Speaking Mexican-Americans	English-Speaking Mexican-Americans
28. Use of Birth Control				
Yes	77.5%	70.0%	73.9%	68.8%
No	22.5%	30.0%	26.1%	31.2%
29. Birth Control after Which Child	1.72	3.34	3.92	3.17
30. Birth Control Before or after First, Middle, or Last Child				
Before First	17.2%	1.8%	0.0%	2.2%
After First	41.4%	27.3%	15.4%	31.0%
After Middle	10.3%	7.3%	0.0%	9.5%
After Last	31.0%	63.6%	84.6%	57.1%
31. Year First Used Birth Control	61.07	62.95	63.46	62.79
32. Help from Relative after Birth	52.6%	75.0%	84.2%	72.1%
33. Number of Miscarriages	14.52	7.69	8.61	7.42
34. Number of Stillbirths	3.12	0.25	0.00	0.33
35. Number of Children Deceased	0.35	4.68	5.52	4.43
36. Number of Premature Births	6.05	5.31	0.70	6.69
37. Number of Pregnancy Complications	13.89	23.40	5.22	16.41
38. Number of Birth Defects	1.33	0.78	0.70	0.81

Table 1. Profile of Population (Averages and Percentages)--Continued

CHILDBEARING HISTORY	Anglo-Americans	Mexican-Americans	Spanish-Speaking Mexican-Americans	English Speaking Mexican-Americans
39. Types of Birth Control Used*				
Birth Control Pill	22.00	37.00	12.00	35.00
Diaphragm	8.00	17.00	4.00	13.00
Hysterectomy	0.00	5.00	1.00	4.00
Foam	3.00	7.00	1.00	6.00
Condom	3.00	1.00	1.00	0.00
IUD	1.00	3.00	2.00	1.00
Rhythm	4.00	10.00	2.00	8.00
Other	4.00	3.00	1.00	2.00

*Raw data

hospitals by doctors. She visited a doctor fairly early in her pregnancies, receiving prenatal care at about the third month. After her return from the hospital, she remained in bed or rested for an additional 5 or 6 days, during which time she received assistance with household tasks from a relative, usually her mother or her mother-in-law. She nursed each child approximately four months. When quizzed, she replied that 4 or 5 children were the ideal number desired by a family.

Description of the Anglo-American Population of the Sample

In some ways Mrs. Wilson, the typical Anglo, is very similar to Mrs. Garcia, while in others she is quite different. She is 33 years old. She was born outside of Arizona and had 4 or 5 brothers and sisters. She almost completed high school, having completed half of her twelfth year of education. Her husband is almost 36. He was raised in a family of 4 and graduated from high school. He earns $6,700 per year.

The Wilsons were married when she was almost 19. Their first child was born when she was 21, and their 3 children were each born over 3 years apart (38½ months). She began receiving prenatal care at about 9 weeks after conception. The Wilson children were all born in hospitals and delivered by doctors. Mrs. Wilson nursed each child for one month, and felt that 3 or 4 children were ideal.

Results of Statistical Analysis

Without minimizing the problems inherent in comparing Anglo-Americans and Mexican-Americans of somewhat different socio-economic

backgrounds, the statistical analysis seems to indicate that there are indeed differences between Mexican-American and Anglo-American women in regard to childbearing practices. Some differences also show up among women of different income levels, irrespective of ethnicity. Nevertheless, it seems that ethnicity is the most significant indicator, since it can explain more instances of behavioral disparity, those usually at a high significance level. Table 2 lists F and X^2 values for particular variables based on data elicited from both Mexican-Americans and Anglo-Americans. The corresponding levels of significance are indicated.

The data are extensive. The findings are summarized briefly as follows:

1. Mexican-American women were born into families significantly larger than those of Anglos, with an average of 7.313 siblings for Mexican-Americans versus 4.641 for Anglo-Americans. Income plays no significant part in predicting size of family orientation.

2. Mexican-American women bear their first child sooner after marriage than do Anglo-American women. Mexican-American women bear a child after approximately 11 months of marriage, while Anglo-Americans do not bear their first child until they have been married about 21 months.

3. Mexican-Americans have a larger number of children than do Anglo-Americans, 4.19 versus 2.85 on the average. The variation in number of births as a function of income is not significant.

Table 2. Relation of Language/Ethnicity and Income to Childbearing Data.

Computed Values of the Statistics F and X^2 for Language/Ethnicity and Income Based on Childbearing Data Elicited from Mexican-Americans and Anglo-Americans (Significance levels of .05 and .01 are indicated by * and ** respectively).

F-Values (One-Way Analysis of Variance	Language/Ethnicity	Income
Age at Marriage	3.35	
Mother's Family Size	14.56**	1.02
Mother's Age at Birth of 1st Child	0.01	0.21
Number of Births	10.42**	1.30
Number of Deceased Children	7.32**	3.10*
Percentage Delivered in Hospital	8.04**	2.62*
Percentage Delivered by Doctor	3.26	0.84
Percentage of Pregnancies Receiving Prenatal Care	3.58	1.53
Month of Inception of Prenatal Care	5.95*	2.15
Nursing Time (Months)	13.30**	1.20
Days of Bedrest after Birth	0.80	0.20
Ideal Family Size	19.69**	2.14
Percentage of Sedations	0.00	1.66
Months of Spacing	1.64	3.24*
Spacing after 1st Child (Months)	0.25	1.31
Spacing after 2nd Child	1.67	4.60*
Spacing after 3rd Child	0.04	0.60
Birth Control after Which Child	9.60**	0.59
Year First Used Birth Control	1.74	0.64
Number of Miscarriages	5.13*	2.19
Number of Stillbirths	7.08**	0.05
Number of Premature Births	0.06	1.53
Number of Pregnancy Complications	2.68	1.32
Number of Birth Defects	0.39	2.26
Months Between Marriage and 1st Child	14.55**	0.64

Chi-Square Values	Language/Ethnicity	Income
Use of Birth Control	0.80 (1 d.f.)	5.55 (3 d.f.)
Type of Birth Control	0.93 (7 d.f.)	28.48 (21 d.f.)
Birth Control after 1st, Middle, or Last Child, or Before 1st Birth	8.28 (2 d.f.)*	5.23 (9 d.f.)
Help from Relative after Birth	5.90 (1 d.f.)*	2.77 (3 d.f.)

4. Both ethnicity and income seem to be factors in the mortality rate of children. Mexican-Americans have more deaths among children than do Anglo-Americans, while lower income groups in general have more deaths among children than higher income groups. However, the significance level for ethnicity is .01 while that for income is .05. If one scans the data for income and ethnicity, it can be seen that income effects a difference primarily upon the Mexican-American population since the mortality level is extremely low for all income groups among Anglo-Americans.

5. The month of inception of prenatal care seems to be a function of ethnicity rather than income. Mexican-American women receive prenatal care later than Anglo-American women, at an average of 2.968 compared to 2.375 months.

6. Ethnicity plays a significant role in the determination of ideal family size with Mexican-American women desiring more children than do Anglo-Americans. Again income makes no significant contribution to differences.

7. There is a significant difference according to income only, in the spacing of children. The major difference occurs in the highest income group, those making more than $8,000 per year, where average spacing is more than 14 months greater than among families of any of the other income groups. Ethnicity is not an important influence in spacing of children.

8. In connection with the spacing of children noted above, the increase in spacing time for the highest income group occurs after the

second child, as the significance level of .05 for this variable indicates. Again, ethnicity is not significant.

9. Use of birth control is not significant for either income or ethnicity. Thus Mexican-Americans show no marked difference from Anglo-Americans in the utilization of birth control. Neither do different income groups of the total population exhibit differences in percentages of women employing birth control.

10. Mexican-Americans, however, do exhibit a different <u>pattern</u> of birth control use. They generally begin use of some means of contraception after their last child, while Anglo-Americans begin much earlier. No such significant difference is noted among income groups.

11. After the birth of their children, Mexican-American women receive help from relatives significantly more often than do Anglo-Americans. This is probably a function of proximity of relatives and birthplace of women. A large percentage of Mexican-American women are native of and have relatives in Tucson or nearby towns of Arizona and Mexico. Income, on the other hand, plays no role in this practice.

12. Two other variables have been determined to be significant in terms of ethnicity rather than income. These are miscarriages and stillbirths. The figures show that the number of miscarriages and stillbirths are far greater for Mexican-American women than for Anglo-American women. However, because of the size of the sample, this does not seem to be a valid index. It can be referred to as a possible indicator, but this data will not be utilized in the following analysis.

Independent Evaluation of the Mexican-American Data

When Mexican-Americans are tested separately for differences in childbearing patterns (Table 3), the results tend to confirm those results derived from the analysis of the data of the entire population, including both Mexican-Americans and Anglo-Americans. On the basis of income, there is again a significant difference in number of deceased children and spacing after the second child. Not unexpectedly, lower income families show evidence of a higher mortality rate among children, and the highest income group, composed of those making more than $8,000, exhibits greater spacing of children, occurring after the second birth. However, overall there do not appear to be wide variations in childbearing behavior among the different income levels within the Mexican-American population.

It should also be noted that the number of statistically significant variables is also considerably reduced when the Mexican-American group is tested separately on the basis of language/ethnicity. Thus, when English-speaking Mexican-Americans are compared to Spanish-speaking Mexican-Americans, important differences in behavior occur only in nursing time and utilization of sedation. Other variables, including month of inception of prenatal care, number of births, ideal family size, and spacing in general, are no longer significant when tested only among Mexican-Americans as they were when tested among the entire population. It appears that the differences in childbearing within the Mexican-American community are slight in contrast to the differences between Mexican-Americans and Anglo-Americans.

Table 3. Relation of Cultural and Socioeconomic Variables to Mexican-American Childbearing Data.

Computed Values of the Statistics F and X^2 based on Childbearing Data Elicited from Mexican-American Women for the Variables: Language/Ethnicity, Income, Education of Mother, Age of Mother, Occupation of Mother, Religion, Education of Father (Significance levels of .05 and .01 are indicated by * and ** respectively).

F-Values (One-way Analysis of Variance	Language/ Ethnicity	Income	Mother's Age	Mother's Education	Religion	Mother's Occupation	Father's Education
Age at Marriage	2.27	1.49	2.70*	0.26	6.64**	0.32	0.07
Mother's Family Size	1.18	0.96	1.19	3.56*	0.45	1.09	0.54
Mother's Age at Birth of 1st Child	3.65	0.88	4.19**	0.68	4.60**	1.08	0.09
Months Between Marriage and 1st Child	0.29	0.63	2.59*	2.71	2.19	1.38	0.55
Number of Births	0.02	2.22	7.48**	4.82**	0.68	3.75**	1.61
Number of Deceased Children	0.21	2.73*	3.38*	2.56	0.51	2.53	0.87
Percentage Delivered in Hospital	3.46	2.18	8.15**	11.21**	0.01	2.76	3.50**
Percentage Delivered by Doctor	0.24	0.68	1.78	3.09	0.05	0.82	1.72
Percentage of Pregnancies Receiving Prenatal Care	0.07	0.82	1.38	3.02	0.02	1.14	3.33**
Month of Inception of Prenatal Care	0.00	1.59	0.64	3.06	0.13	1.42	2.08
Nursing Time (Months)	8.56**	1.12	4.82**	4.15	0.02	0.55	0.39
Days of Bedrest after Birth	2.35	0.26	1.45	1.17	1.34	0.66	0.33
Ideal Family Size	3.27	2.66	1.10	1.27	0.10	4.31**	5.14
Percentage of Sedations	9.30**	0.78	1.63	2.32	0.02	0.23	7.64
Months of Spacing	0.13	1.15	1.97	1.57	0.08	7.28**	0.55
Spacing after 1st Child (Months)	0.67	0.75	1.80	0.80	0.93	5.75**	0.05
Spacing after 2nd Child	1.64	2.90*	0.66	3.45*	0.06	2.64*	2.05
Spacing after 3rd Child	0.85	0.31	1.29	0.29	2.03	0.09	3.32
Birth Control after Which Child	0.86	1.13	4.48**	2.40	0.84	0.27	3.07*
Year First Used Birth Control	0.14	0.15	7.13**	.04	0.00	0.53	0.74
Number of Miscarriages	0.13	2.26	0.47	1.34	0.92	0.50	0.02
Number of Stillbirths	0.30	1.05	0.60	0.69	0.06	5.45**	0.64
Number of Premature Births	3.06	1.00	0.66	0.93	0.57	0.53	0.64
Number of Pregnancy Complications	2.98	2.15	0.56	3.05	1.04	0.60	1.28
Number of Birth Defects	0.01	1.25	0.57	0.67	0.24	1.38	1.35

Table 3. Relation of Cultural and Socioeconomic Variables to Mexican-American Childbearing Data--Continued

Chi-Square Values	Language/ Ethnicity	Income	Mother's Age	Mother's Education	Religion	Mother's Occupation	Father's Education
Use of Birth Control	0.22(3 d.f.)	8.16(3d.f.)*	21.64(4d.f.)**	5.27(2d.f.)	1.22(1 d.f.)	1.18(2d.f.)	3.83(2d.f.)
Type of Birth Control	7.00(7 d.f.)	32.63(21d.f.)	31.64(28d.f.)	19.42(14d.f.)	6.43(7 d.f.)	16.27(14d.f.)	7.21(10d.f.)
Birth Control after 1st, Middle, or Last Child, or Before 1st Birth	3.51(2 d.f.)	1.03(6d.f.)	4.50(8d.f.)	8.23(4d.f.)	0.25(2 d.f.)	2.23(4d.f.)	4.28(4d.f.)
Help from Relative after Birth	1.13(1 d.f.)	4.24(3d.f.)	5.13(4d.f.)	2.00(2d.f.)	1.40(1 d.f.)	2.02(2d.f.)	3.21(2d.f.)

Although it has proved impossible to test for interaction, there is some indication that interaction of income and ethnicity play an important part in behavioral divergences. One variable, use of birth control, shows up as significant only when Anglo-Americans are omitted and Mexican-Americans are tested separately in terms of income level. In use of birth control, the total population exhibits a pattern in which lower income individuals show less acceptance of contraception than upper income individuals, although the differences are not as pronounced as among Mexican-Americans where the difference is significant.

Using data from the entire population tested and then from Mexican-Americans for corroborative purposes, the analysis seems to support the proposition that differences exist in childbearing patterns which can more easily be explained by differences in ethnicity than by differences in income, although economic level often seems to be a contributing factor and should not be ignored.

The effects of other variables should also be noted in describing differences in childbearing among Mexican-American women. Education of mother and father, which could not be tested on the entire population because of the disparity in education level between Mexican-Americans and Anglo-Americans, seem to exert some influence upon childbearing data when Mexican-Americans are tested separately. Statistically significant results are noted for mother's education level in the following variables: mother's family size, nursing time, and spacing after the third child. As might be expected, Mexican-American

women on the lower education rung were born into larger families, nursed their children longer, and showed a smaller period of spacing between their second and third children than those of higher education levels.

The following variables are correlated with father's education: number of pregnancies which received prenatal care, ideal family size, percentage of pregnancies for which sedation was received during delivery, and spacing occurring between the third and fourth child. The data show that wives of men with low education level receive prenatal care for fewer pregnancies than those of upper education levels. Father's education is inversely proportional to ideal family size. Wives of men in the categories of less than eight years of education, greater than eight but less than twelve years of education, and twelve or more years of education desire 4.75, 4.35, and 3.57 children respectively. Wives of men with less than an eighth-grade education received sedation during labor about half as often as other Mexican-Americans. This can only be partly be explained by the fact that the greatest proportion of women who delivered outside a hospital occurs among this group. The final variable, spacing after third child, does not seem to follow the trend previously noted. Families in which the father has less than an eighth-grade education manifest greater spacing than any of the other groups. In summary, socio-economic factors do affect childbearing behavior among Mexican-Americans. The impact is not as obvious as that exerted by ethnicity, however, either in number of variables affected or in degree of significance level. Moreover, those

factors affected do not seem to fall into any discernible pattern, as do variables influenced by ethnicity. This pattern which emerges will be clarified later in this paper.

Several other variables have been suggested as being closely tied to childbearing data. That the Roman Catholicism of most Mexican-Americans would affect such variables as ideal family size, number of births, and use of birth control has often been taken for granted. To gauge the importance of religion upon childbearing behavior, it would be best to compare Catholic Mexican-Americans with Protestant Mexican-Americans. However, because of the small number of the latter, this proves to be impossible in a study such as this. Hence, the values in Table 2 give little indication of possible contrasts in behavior between these two groups. In terms of use of birth control, the data indicate that there is no significant difference between Anglo-Americans, of whom most are Protestants, and Mexican-Americans, the overwhelming majority of whom are Catholic (Table 2). It is interesting to note, however, that while 77.5 percent of all Anglo-Americans in this study have used birth control at some time, only 66.66 percent of Anglo-American Catholics have used it. On the other hand, 72 percent of Mexican-American Catholics have used birth control, while the Mexican-American population as a whole shows 70 percent acceptance. Although the statistical evidence is not definitive, there is an indication that the Catholic Church exerts far less influence in this realm upon Mexican-Americans than might previously have been supposed.

In the introduction to this paper, it was stated that this research would attempt to assess change in childbearing data over time. One traditional aspect of childbearing behavior is securely tied to age of mother, that is the place and agent of delivery. Reflected in the fact that home delivery and delivery by a partera (midwife) ceased many years ago is the finding that no woman under 30 in this study has had a baby delivered at home or by any person other than a medical doctor. There are a number of other variables which are so directly related to age of mother that they lose their value in evaluating behavior, among them number of births and age at marriage. Thus, the only statistically significant analysis of variance score which is useful is the one concerned with nursing. This score suggests that in general women in the past nursed their children longer than do women today.

At first glance, the effect of woman's occupation upon childbearing might seem obvious. Among the categories in which significant differences appear are: number of births, ideal family size, months of spacing, and spacing after the second child. One is apt to assume that women who work outside the home desire and have fewer children, and space those children they do have farther apart. Although the number of working women is quite small in comparison to those who are full-time housewives, an inspection of the data reveals precisely the opposite results from those expected. Women who work full-time outside the home have many more children than those who stay at home, and their children are spaced quite closely together. It appears that

these women work out of economic necessity more than for any other reason, and informal discussion with women confirms this. The part-time workers, however, do manifest the expected pattern suggested above. They want fewer children and have fewer, spaced farther apart than either the children of full-time housewives or full-time workers outside the home. It can be hypothesized that Mexican-American women who work part-time outside the home do so out of desire rather than financial need. The same pattern which exists among Mexican-Americans seems to appear among the entire population including Anglo-Americans.

Pattern Emerging from Statistical Data

The foregoing data reveal that while differences in child-bearing cannot be attributed to one source, ethnicity seems to have a greater impact than do socio-economic influences. Moreover, the differences which occur as a result of ethnicity seem to form part of a discernible pattern. The differences which are significant according to ethnicity can be characterized as being linked to the primacy of the family in Mexican-American social relationships. The family remains a very important unit for Mexican-Americans, who were raised in very large families themselves. They desire more children than do Anglo-Americans and they actually bear more children, although a greater percentage of their children die during childhood. Mexican-Americans have accepted birth control, yet they do not utilize it to "plan" their families, that is to space their children. Instead they employ contraception only after the family includes 3 or 4 children. More often they begin birth control after they feel the family is

complete, whereas Anglo-American women begin early in the procreative period. The extended period of breast feeding characteristic of Mexican-American women probably serves to increase familial solidarity. In any case, Mexican-American women feel that prolonged nursing encourages an intimacy between child and mother, and through mother with the rest of the family, that early weaning would discourage. Aid from relatives after the birth of the child also serves to increase familial solidarity while at the same time extending the immediate kinship boundaries. Although families are nuclear, relatives outside the family of procreation are encouraged to participate in activities surrounding the birth process. Although merely a hypothesis, it might be suggested that Mexican-American women seek prenatal care later than do Anglo-Americans in part because they can seek the help and advice of relatives, which is less available to Anglo-Americans.

Most of the premises above seem to have been substantiated in discussions with the Mexican-American women interviewed. Before reviewing the non-quantifiable data, however, it is necessary to explore one more premise made _a priori_ in formulating this research, namely that unacculturated Mexican-Americans, defined as those who speak only Spanish, would depart even further than acculturated, or English-speaking, Mexican-Americans from Anglo-American norms. This assumption has not been confirmed by the evidence. When the Mexican-Americans were separated by their ability or inability to speak English, two variables proved to be statistically significant at the .05 level. These were nursing time, with Spanish-speakers nursing longer than

English-speakers, and number of sedations, with Spanish-speakers receiving sedation less often during delivery than English-speakers. When an attempt was made to refine the criteria by which acculturation was judged, the results remained basically the same. The Mexican-American population was divided according to use of Spanish in the home (approximate percentage of time Spanish was spoken by mother), community characteristics (concentration of Mexican-Americans in the area), and birthplace of mother. Although isolate instances of significance occurred when tested on the basis of these criteria, there was no overall pattern of variation which could be noted between acculturated and non-acculturated Mexican-Americans.

CHAPTER 5

SOME ANALYSIS OF THE NON-QUANTIFIABLE DATA

A traditional pattern of childbearing described by van der Eerden (1948), Clark (1959), Officer (1964), and Madsen (1964) seems not to be practiced by Mexican-American women in Tucson. There is no longer a choice between delivery at home or in the hospital and none of my informants knew of the existence of a partera in the area. Few traditional Mexican folk practices are observed by Mexican-American women, and the few that do remain are held by only a small proportion of the population. The following is a list of those remaining:

1. Eight percent of the women wore la faja, a belt traditionally worn by Mexican-American women during pregnancy. Officer (1964: 182) records an informant's explanation that such a belt was used to prevent the baby from coming out through the mouth. Although this explanation was given me, a more common explanation was to keep the stomach from getting too big, and in a couple of cases the belt was replaced by a panty girdle as a seemingly appropriate substitute.

2. Six percent observed la dieta in some manner or another. La dieta is the forty-day period after the birth of the child during which the mother is expected to abstain from certain foods, to rest, and to refrain from bathing either herself or her newborn. Likewise, sexual intercourse is prohibited during this period. Not all the women who observed this custom followed all of the restrictions, the younger

women mentioning that they ignored the prohibition against bathing especially. A number asserted that they followed la dieta upon the insistence of a mother or grandmother who came to assist the new mother after the birth of the child.

3. Five percent followed the practice of wearing keys during an eclipse, since according to Mexican folk belief metal such as keys will ward off defects like cleft palate which are said to be caused by eclipses. Three others, although they wore no keys, were influenced by the belief. One mentioned that there was no eclipse during her pregnancies, and therefore she wore no keys. The other two did not wear keys, but both became frightened during the eclipse and one even hid.

4. Two percent of the women sought out abdominal massages, a common practice in Mexico, as Kay (1966: 8) observed.

5. Two percent expressed the belief that a pregnant woman must remain active during pregnancy or she will have difficulty with the delivery.

6. In addition, the following beliefs were professed. One woman maintained that a snake would be afraid of a pregnant woman; another stated that a pregnant woman should not raise her arms to hang wash or do housework for fear that the baby would be strangled by the umbilical cord. One young woman dressed her newborn twin, the other twin having died shortly after birth, in a habito, a cloak worn until it wore out, which was supposed to insure good health. And one mother informed me that she tied the baby's navel with rags "so that it

would stay in" and that she put peppermint and oil on the navel to prevent colic in the child.

Thus, we can see that the traditional Mexican folk practices had not disappeared completely from the urban environment. Indeed these were not a preserve of older or Spanish-speaking Mexican-Americans, but were exhibited also by younger, fluent English speakers. Nevertheless, one could not say that these were extensively practiced by the Mexican-American women in Tucson. In fact, many claimed no knowledge of such practices, and others contended that it was only the ignorant and poor who followed the folk beliefs.

Does this mean that there was nothing particularly "Mexican-American" in the childbearing behavior of these women? Based upon a consideration of both the statistical and non-statistical data, the answer would be no. The information elicited from the informal interviews with Mexican-American and Anglo-American women confirms many of the conclusions derived from the statistical data and points to other areas of divergence between Anglo-Americans and Mexican-Americans in regard to childbearing.

The apparent emphasis on kinship which was manifested in the statistical analysis is reinforced by the expressions of informants. Mexican-American women of this study stress the centrality of the family in their value scheme. Large families are desirable because they provide important social relationships for all members. Although birth control is widely accepted, no interest in the spacing of children is expressed. If children are born close together, they will

enjoy each other's company more, and family ties will be strengthened. Rubel (1960: 812) finds this emphasis on the family to be one of the "core values" of Mexican-Americans. It is not unexpected then that Mexican-Americans not only bear a significantly larger number of children than do Anglo-Americans but also desire more children. It is interesting to note that the average number of births among the Mexican-American population studied is smaller than the number of children felt to comprise an ideal family. Many of these women are still in their procreative periods, and, thus, it might be safe to assume that completed families might closer approach the ideal figure of 4.32 or be even larger.

Yet birth control is widely accepted. Grebler et al. (1970: 365) state that 64 percent of the Mexican-Americans in Los Angeles who participated in a survey undertaken by the authors in 1965-66 responded positively to the question, "What do you feel about a married couple practicing birth control?" Unfortunately, that study did not attempt to determine how many people actually used birth control. Among the Mexican-Americans in this study 70 percent used some means of contraception compared to 77.5 percent of the Anglo-Americans. When queried on the reasons for practicing birth control, the women most often answered that their motives were based upon economic considerations. Of the 30 percent who rejected birth control, a large number did so because of the desire to have larger families. Others mentioned that they were too old to use birth control, but that they would have used it if it (referring to the birth control pill) had

existed during their childbearing years. Very few voiced objections to birth control on religious grounds. Religious prohibition as a reason for rejecting birth control was cited more frequently by Anglo-American Catholics than by Mexican-Americans. This is partially reflected in the statistics. Although a larger percentage of Anglo-Americans practice birth control than do Mexican-Americans, the percentages among the Catholics are 72 percent for the Mexican-American Catholics versus 66.66 percent for the Anglo-American Catholics.

The importance of the family to Mexican-Americans is further reflected in attitudes towards working mothers. There is a widespread belief that women should work only out of economic necessity. Mexican-Americans generally feel that it is best for both mother and child that a woman remain a housewife. It is felt that the family provides positive emotional experiences for all its members and its unity should be encouraged. As one informant stated, "It is not good for a woman to work. It is important to care for children. A mother's life revolves around children--she will lose her family and children if she works." It is interesting to note that Anglo-American women hold the same negative attitudes towards working mothers.

Thus, the mother seems to see herself as the central figure in holding the family together. Clark (1959: 119) observes about the Mexican-Americans she studied that they "believe that childbearing is both a privilege and an obligation of married women." The women in this study wholeheartedly endorse this view. The statistical data indicate that Mexican-American women give birth to their first child

earlier in their marriages than do Anglo-Americans. It is stated almost as a truism by informants that women get married to have a family.

Although a woman's primary concern and interest lies with the nuclear family, there is frequent contact with relatives outside this small group. Mothers, sisters, aunts, cousins, and in-laws frequently live nearby and seem to be a constant source of aid and information. Mexican-American women call or visit these relatives often. They have acquired much of their knowledge about childbearing from these relatives. It is no surprise then that Mexican-American women receive aid from relatives after the birth of a child more frequently than do Anglo-Americans. One area in particular in which Mexican-American women receive advice from female relatives is nutrition.

Mexican-American women are quite concerned about diet as part of maternal care, both before and after the birth of the child. Most are able to provide a list of proscribed foods, knowledge of which they have gained usually from their own mothers or other relatives. This is in contrast to Anglo-American women who most often speak only of the necessity of maintaining a low-caloric or low-sodium diet. Clark (1959: 127) mentions that among the Mexican-American women she studied, many avoided fruits such as bananas and citrus fruits as being too acid and therefore causing varicose veins in the pregnant woman. Others found certain vegetables to be "too cold for the stomach." And arguments persisted about the effect on the baby of beans eaten by a nursing mother, some saying that beans were bad for the baby's stomach.

Among the Mexican-American women of this study, the explanation given for the avoidance of certain foods is that they will cause gas in a pregnant woman or later will give the nursing baby colic or diarrhea. Interestingly, these are the same explanations given by the small number of Anglo-American women who do recognize proscribed foods. However, the foods avoided by the two groups do not generally correspond. Anglo-American women mention cabbage, onions, spices, and cauliflower as foods to be shunned. Among the Mexican-American respondents, the foods listed are chile, chocolate, pork, beans, ice, tomato, lemon or other citrus fruit, melon including watermelon and cantaloupe.

A partial understanding of the choice of foods suggested by the Mexican-American women might be provided by the following explanation of Mexican folk beliefs:

> The menstrual period, pregnancy, childbirth, and the postpartum period are also times of above normal heat . . . . In these situations no remedial action is necessary, since with the passage of time the body automatically reestablishes its equilibrium. But while the more than ordinary heat prevails, a person is particularly susceptible to illness caused by the intrusion of cold, and, to a lesser extent, by the intrusion of heat. Thus many precautions must be observed . . . . During pregnancy a woman approaches cold foods with greater-than-normal caution . . . (Foster, 1967: 189-190).

This relates to the belief mentioned by Clark that some foods are too cold for the stomach. Though the foods enumerated by my informants are not all cold foods, they all fall neatly into the hot-cold classification described by Foster; that is, they are generally very hot or very cold. The following is the list of proscribed foods:

Hot	Cold
Chile	Tomato
Chocolate	Lemon or citrus
Ice	Melon:
Pork	Watermelon (especially cold)
Beans	Cantaloupe

Also mentioned by my informants but not by Foster are ice water, ice cream, jello, and coffee. It is possible that the Mexican-Americans have transferred the hot-cold classification to these foods, some of which like jello and ice cream might not have been readily available in Mexico. Of course, it must not be forgotten that my informants are not consciously aware of such a classification, or at least they have not communicated this awareness to me. If this is the basis for the avoidance of certain foods, the Mexican-Americans are not conscious of its underlying rationale. Indeed, the rationale they accept is one offered by a small number of Anglo-American women; that is, that some foods cause gas, diarrhea, or colic.

The other area where traditional behavior might be said to be evident is in the area of religion. The Mexican-American women express their great devotion to certain Catholic figures, among these are St. Ramon and the Virgin Mary. They mention over and over again that they pray to certain special saints or perhaps to "_el angelito_," the angel of a woman's dead baby. This is in distinct contrast to the Anglo-American population. Forty percent of the Mexican-American women mention a specific devotion to a Catholic saint, while none of

the Anglo-Americans mention such prayers. This is especially significant since a large number of Anglo-Americans in the study are Catholic (37.5 percent).

Religious practices surrounding childbearing are informal ones not closely associated with the institutional Church, although certainly not pagan. There is a whole constellation of saints and other religious figures closely associated with the birth process. These include the Infant Jesus, or in another form, the Infant of Prague; St. Ann, the mother of Mary; St. Joseph, the father of Jesus; Mary, under a number of different titles; and St. Ramon. Van der Eerden (1948: 9) notes that in the rural village of New Mexico where she did fieldwork women began a novena of prayers asking for the help of St. Ramon nine days before the expected date of the birth. According to van der Eerden, St. Ramon Nonnato was a Spaniard who was delivered by Caesarean section as his mother lay dying from the plague; however, none of my informants, even those who prayed to him, could supply any information about the saint. Of those who did not devote themselves to any of these saints, a large number turned to a family or a personal saint and repeated prayers which had been passed down in the family.

As suggested previously, Mexican-Americans seem to be little swayed by the doctrinal pronouncements of the Catholic Church in the realm of childbearing. Only seven percent of the women mentioned any religious scruples against the use of birth control. However, five percent of the Mexican-Americans used rhythm as the sole means of birth control compared to 2.5 percent of Anglo-Americans using this

method alone, the former perhaps being under the influence of the Church although this was not voiced. In general, religion as it relates to childbearing for the Mexican-Americans is concerned not with legalistic dicta but rather with a set of comforting and familiar devotional responses. Religion in this context is primarily informal and traditional rather than institutional.

CHAPTER 6

CONCLUSION

Mexican-American childbearing behavior departs from Anglo-American behavior in three distinct areas--family, religion, and cuisine. The traits comprising these areas might be considered to be retentions from traditional Mexican culture which have been maintained despite acculturating pressures from the dominant Anglo-American society. Giving strength to this position are instances of folk practices such as _la dieta_, _la fajada_, and the use of the hot/cold dichotomy as the basis for the prohibition of certain foods during the childbearing period. To maintain that Mexican-Americans behave in a traditional Mexican manner, however, seems to be placing an inordinate importance upon those Mexican cultural "vestiges." The documented instances of folk practices are relatively few. Although Mexican-American women seem to be applying the hot/cold dichotomy to dietary restrictions, they have no knowledge of the underlying traditional Mexican rationale for its use.

At the other extreme, since so many of the traditional childbearing practices, such as employment of a _partera_ for home delivery, use of massages, and the like, have been discontinued, one might be led to the conclusion that Mexican-Americans have been completely assimilated into the American lifeway. Among those who hold this view are Grebler et al. (1970: 423) who state that "to sum up this material

crudely, we found quite a few Mexican-Americans to be 'typical Americans' in all but a few areas of special knowledge or opinion, and not very many who could be said to have a truly distinctive culture."

An alternative explanation which seems to be more acceptable in view of the evidence offered by this study is that there is a definite Mexican-American subculture. This subculture differs from both the traditional Mexican culture and from the American culture. From my discussions with Mexican-Americans of Tucson, I would have to reject the conclusion that most Mexican-Americans are "typical Americans." Tucson Mexican-Americans distinguish themselves from the "Americans" or "Anglos" or "whites," terms which they often use interchangeably, by defining themselves as "Mexican-Americans" or "chicanos" or "mejicanos." This is not a part-time identification. Mexican-Americans feel they are somehow separate from "Americans" despite the fact that most share citizenship and United States origin of birth with Anglo-Americans. There seem to be some Mexican-American cultural expressions which have permeated, I would guess, the entire life of a Mexican-American living in Tucson. These are especially apparent in the realms of kinship, religion, and food. They are not retentions from traditional (i.e., peasant) Mexican culture. This is the trap into which Grebler et al. seem to fall; they are either speaking in terms of cultural maintenance of distinctive traits or they are speaking of almost complete assimilation. When they decide upon the latter as the most acceptable explanation, they have to explain any differences apparent between Mexican-Americans and Anglo-Americans in socio-economic terms.

The data from this study do not indicate that socio-economic variables are most significant in explaining the childbearing behavior and attitudes. There seems to exist a distinct Mexican-American component in such behavior. What Mexican-Americans have carried over from Mexico and retained have not been specific culture traits, rather they have been culture foci or themes (see Beals, 1951) or cores (Rubel, 1960: 809) or value orientations (Kluckhohn and Strodtbeck, 1961). Among these themes are the importance of the family, private devotions to the saints, and Mexican food. Daily manifestations of expression of these themes have been developed within an urban environment to suit the needs of the Mexican-American people. If this study of one aspect of life, childbearing, is any indication, these themes are not isolated in one particular realm of the individual's life, for example the ceremonial realm, but pervade the entire existence of Mexican-Americans.

The behavior and attitudes which can be labeled as Mexican-American are not examples of spectacular or distinctive culture traits. Rather there seem to be subtle distinctions between Mexican-American and Anglo-American childbearing patterns. Superficially, Mexican-American women appear to have accepted wholeheartedly the practices of Anglo-Americans such as birth control, prenatal care, and hospital confinement during the birth of the child. In reality, Mexican-Americans have incorporated these practices into a previously held system of meanings and values, and in the process have transmuted them. They have, in effect, followed a process outlined by Levi-Strauss

(1962) and summarized by Geertz (1968: 554) as follows:

> Human societies, like individual human beings, never create out of whole cloth but merely choose certain combinations from a repertory of ideas anteriorly available to them. Stock themes are endlessly arranged and rearranged into different patterns; variant expressions of an underlying ideational structure. . . .

The acceptance of birth control by Mexican-American women provides an illustration. While birth control is widely practiced, its practice is structured in terms of Mexican-American conceptions about the importance of the family. The family is treated almost as an inviolable unit which must not be subjected to human intervention. Thus, family <u>planning</u>, or the spacing of children, was rarely mentioned by women of this study. The women contend that only economic considerations force them to <u>limit</u> the size of their families. Among Mexican-Americans in contrast to Anglo-Americans, birth control is used only after the family unit is realized and ideal family size has nearly been achieved.

In similar ways, Mexican-American women have restructured Anglo-American practices and remolded traditional Mexican ones. While home delivery has ceased, the practice of receiving care from a relative after the birth of a child has continued as an important means of maintaining solidarity within the extended family. Culinary practices and religious devotions, though modified from traditional Mexican ones, remain an important part of the childbearing process. Rather than being simple retentions from a Mexican past, they seem to be symbols of Mexican-American ethnicity. This does not mean that Mexican-Americans do not seriously participate in these practices and look upon them only as symbolic; rather, practices within these areas

enable Mexican-Americans to identify themselves as a distinct ethnic group from the dominant Anglo-American society. Thus, considering themselves a group apart, Mexican-Americans borrow, from both Anglo and Mexican practices, strands which they weave into a cultural fabric that is peculiarly Mexican-American.

APPENDIX A

INTERVIEW SCHEDULE

Personal History of Mother

1. Name ____________________
2. Marital Status ____________
3. Age ____________________
4. Religion ________________
5. Birthplace _______________
6. Language ________________
7. Age at Marriage ___________
8. Occupation _______________
9. Number in Family __________
10. Years of Education ________
11. No. of Miscarriages _______
12. No. of Stillbirths ________
13. Use of Birth Control:

    Yes __________ No __________

14. Form: Rhythm _____ Pill _______

    IUD _____ Operation ____ Diaphragm ____

    Other ____________________

15. Year began use of birth control?

    ____

16. Birth control begun after which child? ____________________

Personal History of Father

1. Name ____________________
2. Income ___________________
3. Age ____________________
4. Religion _________________
5. Birthplace _______________
6. Number in Family __________
7. Years of Education ________
8. Occupation _______________

Father of Child from Previous Marriage

1. Name ____________________
2. Income ___________________
3. Age ____________________
4. Religion _________________
5. Birthplace _______________
6. Number in Family __________
7. Years of Education ________
8. Occupation _______________

Name of Child (Star if Deceased)					
Birthdate					
Birthplace					
Delivery Place					
Deliverer					
Prematurity (Baby's Wt.)					
Pregnancy Complica-tions					
Birth Defects					
Prenatal Care: When? Where? How Often?					
Nursing Time					

Guideline for Informal Interview

1. Is special care taken of the mother during pregnancy? by relatives? by friends? by others?

2. Did mother receive help from relatives after the birth of the child?

3. How long is bedrest for the new mother?

4. Did mother receive any type of sedation, caudal, spinal? Was the birth natural?

5. Were there any practices (other than going to an M.D.) that the mother followed during pregnancy to insure the health of the child, e.g., abdominal massages, the wearing of keys, etc.? any special prayers?

6. Was any special practice followed after the birth, e.g., *la dieta*?

7. Are certain special foods eaten during pregnancy? any foods prohibited?

8. Are there special foods prescribed or proscribed during the period after the birth of the child?

9. Feelings about birth control?

10. How many children make up an ideal family?

11. What is felt about women working before, during, or after pregnancy? Do you work?

APPENDIX B

MAP OF AREA OF RESEARCH

The map contained in this appendix shows the area in Tucson, Arizona, where the research for this study was carried out.

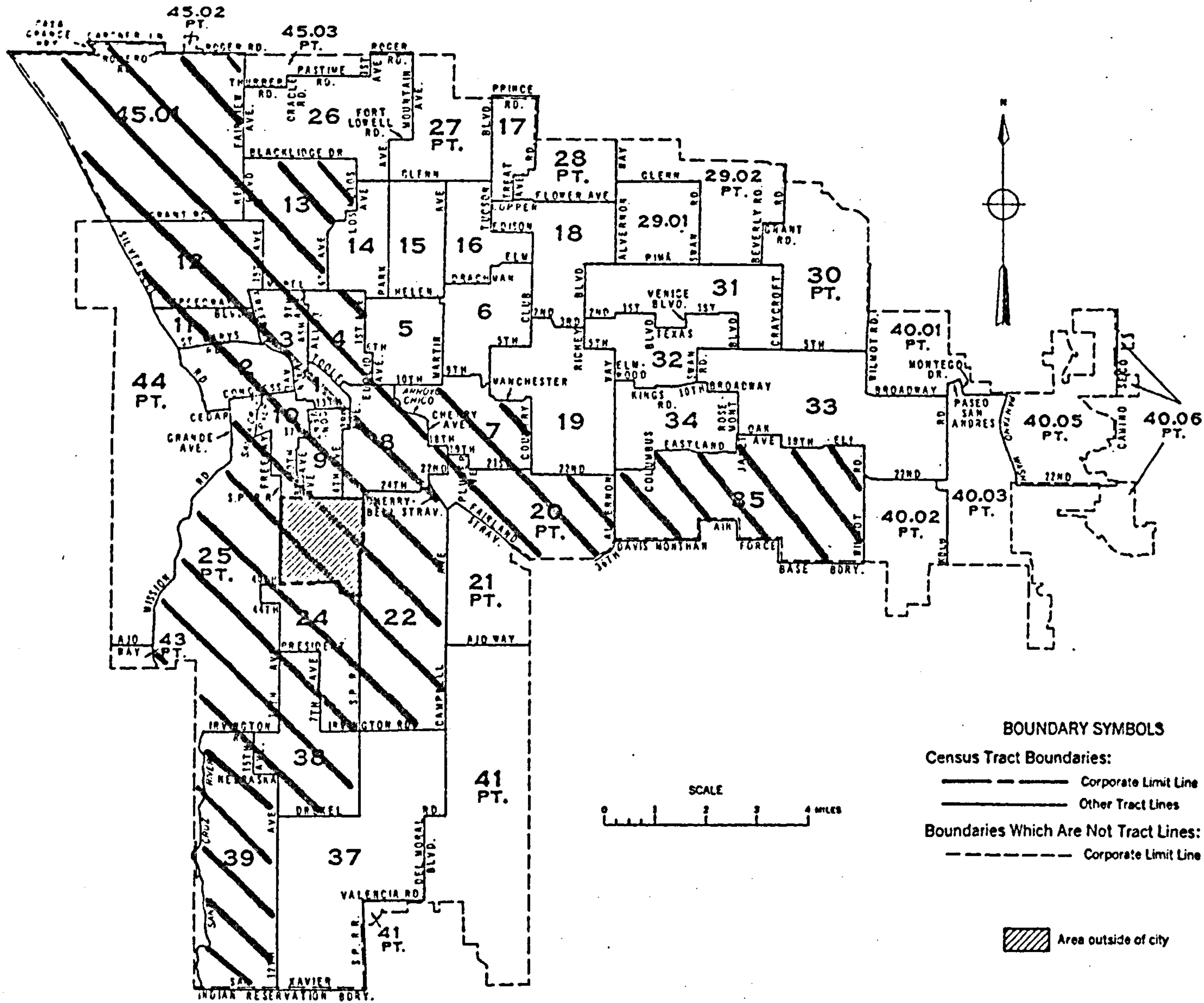

Fig. B-1. Map of Area of Research. (Crossmarks indicate portions of city where study was undertaken.) Source: U.S. Bureau of Census, 1961.

APPENDIX C

EXPLANATION OF ANALYSIS OF VARIANCE AND CHI SQUARE

Analysis of variance is a statistical method for testing significant differences between two or more groups. It is important to note that this method tests for a significance in mean difference among more than two groups _simultaneously_. Thus, the F value which is the result of the computation of analysis of variance indicates whether there is a mean difference among groups. This difference is then clarified by observing the means of the groups in question.

Data which can be measured on an interval scale were analyzed by this technique. These include such variables as age, education, number of children, months of prenatal care, and period of nursing.

In single-classification analysis of variance, as used in this study, one tests for differences in dependent variables among groups representing the consequences of a single independent variable, for example, language/ethnicity represented by the three groups, acculturated Mexican-Americans, non-acculturated Mexican-Americans, and Anglo-Americans. Other independent variables used were income, education of mother, age of mother, occupation of mother, religion, and education of father. The dependent variables were each of those variables for which data was gathered, as noted in the preceding paragraph.

Chi square is used on nominal data, for example those data where a yes/no answer must be given to a question. Here the technique

is used to test differences among samples (the independent variable) with respect to dependent variables, such as use of birth control and type of birth control used. In using X^2, one tests the null hypothesis that the samples are taken from the same population, and that any differences which exist among the groups occur by chance.

The X^2 and F values are comparable in being numerical values resulting from a statistical procedure for determining difference between groups. The resulting value is interpreted for the likelihood of its occurring by chance, according to a probability distribution. If such a likelihood is small, the difference is presumed to be real rather than the product of chance and the null hypothesis (there is no significant difference among the groups) is rejected.

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